STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G408	A. BUILDING **02** B. WING _____	**08/13/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	**4421 FAIRWEATHER DRIVE** **FORT WAYNE, IN 46804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Certification and Environmental Preoccupancy Survey for a replacement facility was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/13/14 Facility Number: 000922 Provider Number: 15G408 AIM Number: 100244500 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code and Environmental Preoccupancy survey, AWS was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies and with 460 IAC 9, Community Residential Facilities for Persons with Developmental Disabilities. This one story facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in sleeping rooms and in common living areas. The facility has a capacity of 8 and had a census of 0 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.6.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G408	A. BUILDING **02** B. WING _____	**08/13/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/18/14.	K 000		